UNITED STATES DISTRICT COURT
DISTRICT OF MINNESOTA

United States of America ex rel. Shelley Rae McCauley and Nancy Bernard,

Plaintiff,

v.

Best Care Home Health, Inc.; Nazneen Khatoon; Grand Rapids Senior Care of Grand Rapids, Inc.; Grand Rapids Senior Care of Grand Rapids, Inc, d/b/a Great River Care; Terrance J. Selb; and Delyte H. Specht and Carl Specht d/b/a Golden Heart Home Health Care,

Defendants.

Civ. No. 98-1261 (RHK/SRN)
MEMORANDUM OPINION AND ORDER

D. Gerald Wilhelm, Assistant United States Attorney for the District of Minnesota, Minneapolis, Minnesota, for the United States.

Jonathan M. Bye, Lindquist & Vennum, P.L.L.P., Minneapolis, Minnesota, for Defendants Best Care Home Health, Inc. and Nazneen Khatoon.

Introduction

The above-captioned matter represents the consolidation of two separate qui tam actions brought by different relators against the above-named Defendants pursuant to the False Claims Act ("FCA"), 31 U.S.C. §§ 3729-3733. The United States intervened on March 15, 2001, and prepared the Consolidated Amended Complaint that is currently the operative pleading in this action. The FCA allegations in the Consolidated Amended

Complaint involve several categories of claims submitted to Medicare for home health care services, including Medicare claims for services provided in 1996 and 1997 to residents of Manor House, an assisted living facility in Grand Rapids, Minnesota.

Presently before the Court is Defendants' Best Care Home Health, Inc. ("BCHH"), and Nazneen Khatoon's (collectively, "the Best Care Defendants") Motion for Partial Summary Judgment on that portion of the United States's FCA claims relating to "waivered services."[1] The United States alleges that certain claims made to Medicare for services provided to Manor House residents were not properly reimbursable, and were in fact false, because Medicaid had already paid for the same services. The Best Care Defendants argue that the FCA claims arising from payments received for "waivered services" should be dismissed for two reasons: (1) the United States has failed to plead fraud with particularity, as required by Rule 9(b) of the Federal Rules of Civil Procedure, and (2) the United States's theory for liability rests on a legally flawed assumption that

[1] BCHH and Khatoon also seek summary judgment on *all* of the claims against them on the grounds that the United States has the wrong corporation in the gun sights. BCHH and Khatoon argue that the corporation that submitted the allegedly false claims to Medicare was not BCHH, as alleged in the Consolidated Amended Complaint, but rather a corporation called "Best Care, Inc." At the hearing on the Defendants' Motion, counsel for the United States and the movants advised the Court that (1) the United States has prepared a Second Consolidated Amended Complaint naming "Best Care, Inc." as a defendant, (2) counsel for Defendants BCHH and Khatoon have signed a stipulation consenting to the amendment, (3) the United States is in the process of obtaining consent to the stipulation from counsel for Defendants Terrance Selb and Grand Rapids Senior Care, and (4) the United States intend to voluntarily dismiss the Spechts (d/b/a "Golden Heart Home Health Care") who have appeared pro se in this matter. Because counsel for BCHH and Khatoon have agreed to an amended pleading that includes "Best Care, Inc.," as a party, the Court determines that a controversy no longer exists on that issue.

Medicare is the "secondary payer" to Medicaid when, in fact, Medicare is the "primary payer." For the reasons set forth below, the Court will grant the Defendants' Motion for Partial Summary Judgment.

Background

The Defendants' Motion focuses on those allegations in the Complaint pertaining to "waivered services." Under Medicaid — the state-administered and federally-funded health insurance program for the poor created by the federal Social Security Act — a state may apply for "waivers" from the United States Secretary of Health and Human Services in order to use Medicaid funds to pay for certain home or community-based services that would not otherwise be furnished under the state's Medicaid plan. See 42 U.S.C. § 1396n; 42 C.F.R. § 440.180 (describing "home or community-based services" and setting out requirements for coverage under Medicaid). Thus, in 1996 and 1997, Minnesota's "waiver" programs used federal financial support to expand the availability of services for, inter alia, elderly individuals who were eligible for medical assistance, Minn. Stat. § 256B.0915, subd. 1 (1996 & 1998) (the "Elderly Waiver" program). During the relevant time frame, Minnesota also offered an "Alternative Care" program for "frail older Minnesotans" who either (1) were receiving medical assistance and were being served under the medical assistance program or the Medicaid waiver program, or (2) would be eligible for medical assistance within 180 days of admission to a nursing facility. Minn.

Stat. § 256B.0913, subd. 2 (1996 & 1998) (the "Alternative Care" program).[2]

Minnesota's programs for the elderly paid for some services that are also reimbursable under Medicare, such as home health aide services and skilled nursing services. See Minn. Stat. § 256B.0913, subd. 5(a)(3) and (13) (1996 & 1998) (the Alternative Care" program); Minn. Stat. § 256B.0915, subd. 3(c) (1996 & 1998) (the "Elderly Care" program); cf. 42 U.S.C. § 1395x(m)(1) & (4) (Medicare definition of "home health services"). Since 1996, Minnesota has maintained a "Medicare Maximization" program, which required the Minnesota Commissioner of Human Services to establish a technical assistance program that would enable the providers of "home care services" to maximize collections from the federal Medicare program.[3] Minn. Stat. § 256B.071, subd. 2(a) (1996 & 1998). The "Medicare Maximization" program further provided that

> [a]ny provider of home care services enrolled in the medical assistance program, or county public health nursing agency responsible for personal care assessments, or county case managers for alternative care or medical

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[2] Through the Alternative Care program, the Minnesota Legislature sought to limit nursing facility placements and to support the elderly in their desire to remain in the community as independently and for as long as possible. Minn. Stat. § 256B.0913, subd. 1 (1996 & 1998). Thus, funding under the Alternative Care program was generally not available for individuals who resided in licensed nursing homes or boarding care homes. Id., subd. 4(c).

[3] The statute defines "home care services" as "home health agency services, private duty nursing services, personal care assistant services, **waivered services**, alternative care program services, hospice services, rehabilitation therapy services, and suppliers of medical supplies and equipment." Minn. Stat. § 256B.071, subd. 1(b) (1996 & 1998) (emphasis added).

> assistance waiver programs, *is required to use the method developed and supplied by the department of human services for determining Medicare coverage for home care equipment and services* provided to [recipients eligible for either the medical assistance program or the alternative care program who are also eligible for the federal Medicare program] to ensure appropriate billing of Medicare.

Id., subd. 2(b) (emphasis added).

The Consolidated Amended Complaint alleges that some of the claims submitted by the Best Care defendants to Medicare for services provided at Manor House between January 1, 1996 and October 31, 1997 were not reimbursable because

> [t]he services rendered to Medicare beneficiaries were duplicates of those provided for the same beneficiaries under a Medicaid program known as "waivered services." As such, the claims had already been paid by another third-party payor (that is, Medicaid).

(Consol. Am. Compl. ¶ 27(c).) The United States explained at its Rule 30(b)(6) deposition that the "waivered services" claims present essentially an issue of "double billing":

> The argument is basically condensed to — to mean that Medicare is always a secondary payer. We'll only pay if somebody isn't. Somebody else was already paying, so these services were ineligible to be billed. . . . [T]he whole entire claim is — is false because somebody else was already paying for the service that they're billing for.

(June 19, 2003, Bye Aff. Ex. D at 35.) The United States's proposed expert witness, Carol Cartte of Clifton Gunderson, L.L.P., opines that Best Care received an overpayment from Medicare of $82,586 for home health services rendered to certain Medicare beneficiaries between January 1, 1996 and December 31, 1998. (Suppl. Bye Aff. Ex. A at 1.) Cartte states that this sum represents approximately 1,300 visits, including "29 visits

paid by another source (see discussion of Medicaid Elderly Waiver Program below)."

(Id.) Cartte explains that

> [s]everal claims that would otherwise have been allowable by Medicare were denied since the services were covered under the Medicaid Elderly Waiver Program (EW). EW covers home and community-based services such as visits by skilled nurses, home health aides and personal care assistants for people age 65 and older, meeting certain income and asset requirements. Under § 1862(b) of the Social Security Act (42 U.S.C. § 1395y(b)), Medicare payments may not be made, to the extent that payment has been made, or can reasonably be expected to be made, for Medicare covered items or services under a plan of the United States or a state.

(Id.) The Best Care Defendants do not dispute that the "waivered services" at issue are reimbursable under Medicaid. They also do not dispute that they submitted claims to Medicare for the "waivered services" and, at the same time, Manor House was submittimg claims for the same home health care services to Medicaid for payment under the Elderly Waiver program. (See Suppl. Bye Aff. Ex. B at 24-25.)

Analysis

I. Standard of Decision

Summary judgment is proper if, drawing all reasonable inferences favorable to the non-moving party, there is no genuine issue as to any material fact and the moving party is entitled to judgment as a matter of law. Fed. R. Civ. P. 56(c); Celotex Corp. v. Catrett, 477 U.S. 317, 322-23 (1986); Anderson v. Liberty Lobby, Inc., 477 U.S. 242, 249-50 (1986). The moving party bears the burden of showing that the material facts in the case are undisputed. See Celotex, 477 U.S. at 322; Mems v. City of St. Paul, Dep't of Fire & Safety Servs., 224 F.3d 735, 738 (8th Cir. 2000). The court must view the evidence, and

the inferences that may be reasonably drawn from it, in the light most favorable to the nonmoving party. See Graves v. Arkansas Dep't of Fin. & Admin., 229 F.3d 721, 723 (8th Cir. 2000); Calvit v. Minneapolis Pub. Schs., 122 F.3d 1112, 1116 (8th Cir. 1997). The nonmoving party may not rest on mere allegations or denials, but must show through the presentation of admissible evidence that specific facts exist creating a genuine issue for trial. See Anderson, 477 U.S. at 256; Krenik v. County of Le Sueur, 47 F.3d 953, 957 (8th Cir. 1995).

II. Partial Summary Judgment on the Claims Involving "Waivered Services"

A. Failure to Plead Fraud with Particularity

A complaint alleging violations of the FCA must be pled with particularity pursuant to Rule 9(b). United States ex rel. Costner v. United States, 317 F.3d 883, 888 (8th Cir. 2003), pet. for cert. filed, 72 U.S.L.W. 3093 (U.S. July 8, 2003). Under the requirements of Rule 9(b), the claim must identify the "who, what, where, when, and how" of the fraud. See Parnes v. Gateway 2000, Inc., 122 F.3d 539, 550 (8th Cir. 1997). The Best Care Defendants argue that the Consolidated Amended Complaint is deficient with respect to the "waivered services" claims because it fails entirely to identify (1) the specific Medicare beneficiaries who allegedly were receiving such waivered services, (2) what those specific services were, or (3) the specific BCHH claims that allegedly duplicated those services. (Defs.' Mem. Supp. Mot. for Summ. J. at 4-5.)

The Eighth Circuit recently observed — in an FCA case — that courts must read and apply Rule 9(b) "in the context of the general principles of the Federal Rules, the

purpose of which is to simplify pleading. Thus, the particularity required by Rule 9(b) is intended to enable the defendant to respond specifically and quickly to the potentially damaging allegations." United States ex rel. Costner, 317 F.3d at 888. The Best Care Defendants do not argue that they are unable to respond to the "waivered services" allegations in the Consolidated Amended Complaint. Indeed, the relevant elements of "who, what when, where, and how" are set forth in that pleading. The Consolidated Amended Complaint identifies the time period at issue – the "when" – as the months from January 1, 1996, to October 31, 1997 (the "Best Care Manor House Claims Period"). (Consol. Am. Compl. ¶ 22.) The pleading identifies "who" submitted the allegedly false claims: the Best Care Defendants. (Id. ¶ 27.) The pleading further alleges how the "waivered services" claims were false, quoted above. (Id. ¶ 27(c).) Finally, the Consolidated Amended Complaint identifies twenty-three Medicare beneficiaries who received services that were allegedly not reimbursable because, for some, the Best Care Defendants had allegedly "double-billed" Medicare for services covered by the Medicaid waiver program. (Id. ¶ 28.)

After answering the Consolidated Amended Complaint, the Best Care Defendants took a Rule 30(b)(6) deposition of the United States that covered the factual basis for its "waivered services" allegations. From that discovery, Defendants have formulated a legal challenge to the United States's theory about why the "waivered services" claims were unlawful. The Best Care Defendants have in fact responded to the allegations within months of the Consolidated Amended Complaint being served. They have not met

their burden of showing that the United States's "waivered services" allegations are insufficient under Rule 9(b). The Court therefore turns to the Defendants' second argument.

B. Medicare as the "Primary Payer"

The Best Care Defendants contend that the United States has premised its FCA claim regarding the "waivered services" visits on the erroneous theory that, as between Medicare and Medicaid, Medicare is the secondary payer. The Best Care Defendants acknowledge that, under certain provisions of Medicare, Medicare is supposed to be second in line behind other payers. With respect to *Medicaid*, however, they argue that no provision of Medicare makes Medicare the secondary payer. In support of this assertion, the Best Care Defendants cite a September 11, 2000, letter from the Director of the Centers for Medicare & Medicaid Services to state Medicaid Directors which explicitly states that Medicare is a primary payer to Medicaid, and Medicaid is the payer of last resort. (Bye Aff. Ex. F.)

The United States concedes that, where dual eligibility exists for both the beneficiary served and the service provided — that is, where both Medicare and Medicaid provide coverage — Medicare is the primary payer and should be billed first. (Govt.'s Response to Defs.' Mot. for Summ. J. at 9-10.) The United States makes two counter-arguments, however, to the Defendants' position. First, it asserts that Medicare does not reimburse for "waivered services" in the same manner in which Medicaid reimburses for them; therefore, there is no dual eligibility. Second, it contends that the services provided

in the "waivered services" visits were not "medically necessary" and therefore not covered by and reimbursable under Medicare. The Court addresses each argument in turn.

The United States's "manner of reimbursement" argument rests on the assertion that "[a]ssisted living facilities such as Manor House who are providers of waivered services under contract with the Department of Human Services receive a monthly payment in a lump sum for the 'bundle of services' contracted for each recipient served by the provider." (Govt.'s Response to Mot. for Summ. J. at 9.) From that assertion, the United States argues that no similar "bundled service" coverage exists under Medicare for home health services. The United States has not, however, presented any evidence from which a jury could find that Manor House in fact received a monthly payment in a lump sum for any of the residents who received the "waivered services" at issue in this lawsuit. The United States relies on a subdivision of the "Alternative Care" program statute which in 1996 and 1997 provided that reimbursement for "assisted living services" and "residential care services" would be a monthly rate negotiated and authorized by the county agency. Minn. Stat. § 256B.0913, subd. 5(i) (1996); Minn. Stat. § 256B.0913, subd. 5(j) (1998). That authority is too slender to support the United States's argument.

As a threshold matter, the United States identifies no facts in the record from which a jury could find that the services provided during the disputed "waivered services" visits constituted either "assisted living services" or "residential care services" as defined by the "Alternative Care" program statute. See Minn. Stat. § 256B.0913, subd. 5(a)

(1996 & 1998) (listing eighteen categories of services that could be paid by "alternative care funding," including not only "assisted living services" and "residential care services" but also "home health aide" services, "nursing services" and "personal care" services); id., subd. 5(g) (1996 & 1998) (defining "residential care services); id., subd. 5(h) (1996 & 1998) (defining "assisted living" services). In addition, the United States identifies no facts in the record from which a jury could find that the Manor House residents who received the services underlying the disputed "waivered services" visits were participating in Minnesota's Alternative Care program as opposed to, for example, the "Elderly Waiver" program. Indeed, the United States's expert opined that the "double-billed" claims for "waivered services" involved Minnesota's "Elderly Waiver" program; the subdivision of section 256B.0913 that the United States cites applies only to the Alternative Care program.[4]

The United States's "manner of reimbursement" argument is not only factually deficient, but it also appears to be inconsistent with the law. During the relevant time

[4] The United States also cites Minnesota Rule § 9505.2475 as authority for the proposition that waivered services are "bundled" into a service agreement. That Rule pertains to "alternative care grants" administered under Minn. Stat. § 256B.0913 to pay for services under the "Alternative Care" program. The cited Rule requires only that various people – including the person eligible to receive "Alternative Care" funds, his or her physician, supervising registered nurse, and home health aide (or personal care assistant) – participate in drawing up an individual treatment plan for the grant recipient and revisit that plan on a regular basis. Minn. R. 9505.2475 (1995 & 1997). As discussed above, the United States has placed before the Court no evidence that the Manor House residents involved in the "double-billed" claims at issue were participating in the Alternative Care program.

period, Minnesota's "Medicare Maximization" statute required that providers of "home care services," a term that expressly included "waivered services," maximize collections from the federal Medicare program. Minn. Stat. § 256B.071, subd. 2(b) (1996 & 1998). If "waivered services" were "bundled" and paid in a manner inconsistent with Medicare reimbursement, as the United States contends, it would have been futile for the Minnesota Legislature to direct the Human Services Commissioner to ensure that Medicare payments for such services were maximized. The Court finds no merit in the United States's "manner of reimbursement" argument.

Turning to the question of "medical necessity," the United States seeks to equate a duplicative *claim* with a medically unnecessary *service*. (Govt.'s Resp. to Mot. for Summ. J. at 10.) This argument is a departure from the United States's expert report which cited the "Medicare as secondary payer" provision of the Social Security Act, § 1862(b) (42 U.S.C. § 1395y(b)), as the basis for concluding that services covered by the "Elderly Waiver Program" were not reimbursable under Medicare. Rather than analyze the application of § 1862(b) to the "waivered services" visits, however, the United States argues that the "waivered services" were not medically necessary under § 1862(a)(1)(A) (42 U.S.C. § 1395y(a)(1)(A)). The United States contends that "[i]f an assisted living facility such as Manor House is already providing a *service*, there is no medical necessity for that *service* to be provided by a home health agency." (Govt.'s Response to Defs.' Mot. for Summ. J. at 12 (emphasis added).) There are no facts in the record, however, from which a jury could find that duplicate *services* were provided to Manor House

residents on the challenged "waivered services" visits. The "waivered services" allegations present a situation of duplicative billing for a single service, not the provision of duplicate services, as the United States acknowledged at oral argument.

The Court finds no basis in law or fact for the United States's assertion that duplicative billing for a single service renders that service "medically unnecessary."[5] Accordingly, it concludes that the Best Care Defendants are entitled to summary judgment with respect to the FCA allegations involving "waivered services" because, in the case of double-billing for the same services, Medicare (to whom the Defendants submitted their claims) is the primary payer, and Medicaid is the payer of last resort.

Conclusion

Based on the foregoing, and all of the files, records, and proceedings herein, **IT IS ORDERED** that Defendants Best Care Home Health, Inc., and Nazneen Khatoon's Motion for Summary Judgment or, in the Alternative, for Partial Summary Judgment (Doc. No. 78) is **DENIED** with respect to the request for summary judgment and is **GRANTED** with respect to the request for partial summary judgment. The False Claims Act allegations involving "waivered services" are hereby **DISMISSED WITH PREJUDICE**.

[5] The United States also contends that, pursuant to the Minnesota Health Care Program Provider Manual, it was the Best Care Defendants' obligation to ensure that the services and documentation are coordinated. The "provider" referred to in the manual, however, is the *Medicaid* service provider – i.e., Manor House.

Dated: August 14, 2003

RICHARD H. KYLE
United States District Judge